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.Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

X.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

X.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a X who sustained an industrial injury on X and is seeking authorization X.
Previous treatment has included X. Letter of Medical Necessity dated X states that it is medically necessary for X to continue X. This is vital for X current X. Recommendation is for X. Progress report dated X has the injured worker doing X. X is requesting a referral to X. Height is 71 inches, weight is 374 pounds, and body mass index is 49.3 kg/m2. The exam reveals X noted. The treatment plan included X.

The letter of medical necessity (not dated) cites that the injured worker needs to X. This is beneficial for X. This has helped X back pain and range of motion. Due to weight, X is unable to do much exercises out of the pool. This is necessary for X health improvement. Recommend X does this X. The utilization review dated X non-certified the requested X. The rationale states this request is not medically necessary for this patient with chronic pain (who has no evidence of an X noted.) The patient had X in the past, yet symptoms remain and X notes were submitted for review (X.) The clinical treatment plan in the submitted medicals from X does not correlate with the letter submitted by Dr. X, D.O. from an unknown date. Therefore, the request for X is non-certified.

The utilization review dated X non-certified the requested X. The rationale states in this case, the injury involved the patient's lower back, for which the patient was last seen on X. Post-injury care included X. The patient was diagnosed with spinal stenosis of the lumbar region, with neurogenic claudication. As of the latest provider encounter, X.

Insufficient clinical information was furnished to establish medical necessity.
The utilization review dated X non-certified the requested X. The rationale states the amount of sessions attended and the efficacy of those sessions are unknown. Thus, the request is not medically necessary. The utilization review dated X non-certified the requested X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

As per ODG, "Recommended as an optional form of exercise therapy when there are impediments to performing land-based physical therapy, which has comparable outcomes. X. There may be advantages to weightless running in back pain recovery. A randomized controlled trial suggested that X. The X consisted of X."
Also, as per ODG, "Medical treatment: X visits over X weeks"

This X sustained an industrial injury on X and is seeking authorization for X. X presented on X doing X in the pool, and has dropped some weight as a result. X is requesting a referral to X. Height is 71 inches, weight is 374 pounds, and body mass index is 49.3 kg/m2. The exam reveals X. There are X noted.

However, detailed documentation is not evident regarding sustained functional improvement with the previously attended X. Additionally, an intolerance to land-based therapy, or reasons why this patient is unable to attend a X. Moreover, there is X. The rationale for other than a prescribed and self-administered protocol is not demonstrated at this time. Therefore, the requested X is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**